Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TX HEALTH DBA INJURY ONE DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243-4307

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-2663-01

MFDR Date Received
April 5, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provided and the claims were denied per EOB based on extent of injury. The treatment that was provided is part of his compensable injury to his neck that he sustained on 01/27/09."

Total Amount in Dispute: $17,606.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "1. The MDR section has no jurisdiction over dates of service 01/0811 – 01/28/11. The Division of Hearings has already determined that the Carrier is not liable for payment…The Hearing Officer found that the 10 sessions at issue were not medically necessary…2. Provider is not entitled to payment for any dates because Provider treated only conditions that are not compensable."

Response Submitted by: Stone Loughlin & Swanson LLP, PO Box 30111, Austin, TX 78755

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 22, 2010 through November 4, 2010	Chronic Pain Management	$9,575.00	$9,575.00
January 5, 2011 through January 28, 2011	Chronic Pain Management	$8,031.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the medical fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits

- 219 - Based on extent of injury
- 50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer
- 198 – Pre-authorization/authorization exceeded

Issues

1. Is there an unresolved issue of 'medical necessity' for dates of service January 5, 2011 through January 28, 2011?
2. Is there an unresolved issue of 'extent of injury' for dates of service September 22, 2010 through November 4, 2010?
3. Is the requestor entitled to reimbursement?

Findings

1. According to the respondent's position statement and the explanation of benefits submitted, the workers' compensation carrier denied payment for dates of service January 5, 2011 through January 28, 2011 because the services were not deemed a medical necessity. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or **medical necessity** exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or **medical necessity** shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." Review of the submitted documentation finds that the requestor and respondent were engaged in a medical necessity dispute over dates of service January 5, 2011 through January 28, 2011. A contested case hearing was conducted to resolve the medical necessity dispute. According to a decision rendered on March 17, 2011, the hearing officer concluded that the carrier was not liable for these dates of service because the "additional chronic pain management is not healthcare reasonably required." The requestor did not contest the division's determination as indicated in the division's decision "…Provider Injury One of Dallas did not appear and announced prior to the hearing that it was withdrawing its dispute of the Carrier's appeal of the IRO decision." The division concludes that the medical necessity issue has been resolved, and that no amount can be recommended for payment because the carrier is not liable for payment for dates of service January 5, 2011 through January 28, 2011.

2. According to the respondent's position statement and the explanation of benefits submitted, the workers' compensation carrier denied payment for dates of service September 22, 2010 through November 4, 2010 based on extent of injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, **extent of injury**, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, **extent of injury**, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." Review of the submitted documentation finds that the requestor and respondent were in engaged in disputes over whether the compensable injury extended to include left shoulder, rotator cuff tear, post concussion syndrome, cervical disc protrusion at C5-6, lumbar disc protrusion at L4-5, lumbar sprain, and major depressive disorder with psychosis. Review of the submitted medical bills and medical documentation finds that the chronic pain management services were provided to treat diagnosis code *847.0 Neck sprain and strain.* No documentation was found to support that the respondent is disputing neck sprain and strain. The division concludes that there is no unresolved issue of extent for dates of service September 22, 2010 through November 4, 2010, and that the carrier's denial reason is unsupported. These dates of service are therefore reviewed pursuant to applicable division fee guidelines.

3. Dates of service September 22, 2010 through November 4, 2010 are therefore reviewed for payment. 28 Texas Administrative Code §134.204(h)(5) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier 'CP' for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add 'CA' as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

Dates	Code	Calculation	Allowable
September 22	97799 CP CA	$125 x 4 Hours	$ 500.00
October 7, 18, 19, 20, 22, 26, 28, 29	97799 CP CA	$125 x 58 Hours	$ 7,250.00
November 1, 3, 4	97799 CP CA	$125 x 21 Hrs & 15 Min	$ 2,656.25
		Total Allowable	$10,406.25

The total allowable for the disputed services is $10,406.25, the carrier paid $831.25; therefore an additional $9,575.00 is recommended for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 9,575.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,575.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.